PPW
Payer Provider Workgroup

November 18th, 2019 1:30 pm **Location: 450 W. State St., 7th Floor, Conference Room 7A**

Meeting Minutes:

Member Attendees: Kathy Brashear (phone), Teresa Cirelli, Dr. Kelly McGrath (phone), Neva Santos (phone), Larry Tisdale (phone), Norm Varin, Matt Wimmer (phone), Wren Withers (phone), and Cynthia York

Guests: Mary Sheridan, Elke Shaw-Tulloch, Stephanie Sayegh, Ann Watkins, Shelby-Lyn Besler, Jenni Gudapati, and Krista Stadler

Anti-Trust Statement: It is the policy of the Healthcare Transformation Council of Idaho (HTCI), to conduct all its activities, and the workgroups associated with HTCI's activities, in compliance with federal and state antitrust laws. During these meetings and other activities, including all informal or social discussions, each member shall refrain from discussing or exchanging competitively sensitive information with any other member.

Summary of Motions/Decisions:

Motion:	**Outcome:**
Cynthia York moved to accept the minutes of the October 16th, 2019 Payor Provider Workgroup meeting as presented. Teresa Cirelli seconded the Motion.	Passed

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; and Agenda Review- *Norm Varin and Dr. Kelly McGrath Co-Chairs of the Payer Provider Workgroup*

- Started at 1:35 pm

Improving Sepsis Care Presentation- *Helen Holmes, RN, MBA, and Ann Ealy, RN Kootenai Health*

- Septic shock was 30% in 2017

- Kootenai Health participates in the Mayo Clinic Care network and requested that they provide technical assistance to assist with this project. The Mayo Clinic staff reviewed data, ran reports and made recommendations for improvement as follows:
    - Earlier Resuscitation – establishing earlier Rapid Response team (RRT)
    - Point of Care lactate protocol – compress the time in administering medication
    - RRT training – having the teams made up of physicians, nurses, and EMS crews
- Goal is to decrease the sepsis shock mortality to 20% in 2018, saving an estimated additional 21 lives.
- After implementing a new "ED redesign" process results were reduced to 24.2% in 9 months, representing 12 lives saved with this "ED redesign"
- ICU hours also decreased due to the new process
- Outreach has become a little more complex when it comes to transferring patients both internally and externally.
- EMS now administers the IV treatment (antibiotic medication) while in transport

Telehealth Taskforce (TTF) Update- *Jenni Gudapati, Boise State University, Krista Stadler, St. Luke's Virtual Care Center and Ann Watkins, Office of Healthcare Policy Initiatives, Bureau of Rural Health & Primary Care*

- The three TTF Co-Chairs have met 6 times over the last 3 months and devoted a lot of time on pre-implementation planning
- The TTF will meet from January to June 2020 and will prepare a final report with their recommendations to HTCI and HQPC in August 2020
- A pre-work packet which capture barriers and current telehealth landscape details will be provided to TTF members prior to the January TTF meeting.
- The TTF will be comprised of 12 members 4 from the healthcare sector and 8 members from various economic sectors throughout Idaho. If members of PPW have suggestions for members, please reach out to Jenni Gudapati or Ann Watkins.
- Subject Matter Experts will be invited to present solution-based recommendations on how to further telehealth adoption and expansion in Idaho. Pre and post surveys will be provided to TTF members to help aggregate key points of consensus.
- The TTF meetings also present an opportunity to educate a new group about telehealth and incorporating businesses that are self-funded and community leaders
- Some of the businesses identified to participate in the TTF already have been providing telehealth services and incorporating them in the task force also presents opportunities to strengthen linkages with primary care

New HTCI Workgroup overview- *Mary Sheridan, Bureau of Rural Health & Primary Care*

- Critical Access Hospital (CAH) Workgroup established and will start with a co-chair meeting on December 5th and the first full task force meeting will be held on or around January 23, 2020. The purpose of the CAH workgroup will be to explore funding models like the Pennsylvania global budget model for applicability in Idaho. If possible, a funding application will be submitted to the Center for Medicare and Medicaid Innovation (CMMI) Rural Health Initiative.
- Larry Tisdale and Patt Richesin are co-chairs and 7 CAH representatives have expressed interest in participating in the CAH.workgroup**.**

- Materials are being collected from other funding demonstration models such as Pennsylvania, Maryland and others who have successfully implemented value-based payment models.

Closing- *Norm Varin, Dr. Kelly McGrath Co-Chairs of the Payer Provider Workgroup*

- Dr. David Pate is retiring from St. Luke's and the co-chair position he currently holds for HTCI will need to be filled.
- PPW is still soliciting ideas on payer and provider collaborative projects
- Send an email to Norm Varin, Dr. Kelly McGrath, or Mary Sheridan on any upcoming meeting discussion topics

- Future Meetings: Monday January 27th, 2020 1:30pm – 3:30pm (MST)
  Monday February 24th, 2020 1:30pm – 3:30pm (MST)

Meeting Adjourned: 03:00 pm

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Health Care Payment Learning & Action Network: APM Framework

Emilie Sites, MPH

Project Manager, Comagine Health

Background and Purpose

- The Health Care Payment Learning & Action Network (LAN) was created at the request of Centers for Medicare & Medicaid Services (CMS) to help drive payment reform and alignment across public and private sectors of the U.S. health care system

- A workgroup was convened to establish an alternative payment model (APM) framework that could be used to track progress towards APM adoption and establish a common approach for classifying APMs

- First APM Framework published in 2016, then refreshed in 2017

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Eight Underlying Principles of the Framework

1. Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.

2. Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support.

3. The goal for payment reform is to transition health care payments from FFS to APMs. While Category 2C APMs can be the payment model for some providers, most national spending should continue moving into Categories 3 and 4.

4. Value-based incentives should ideally reach care teams who deliver care.

5. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.

6. Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.

7. APMs will be classified according to the dominant form of payment when using more than one type of payment.

8. Centers of excellence, accountable care organizations, and patient-centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

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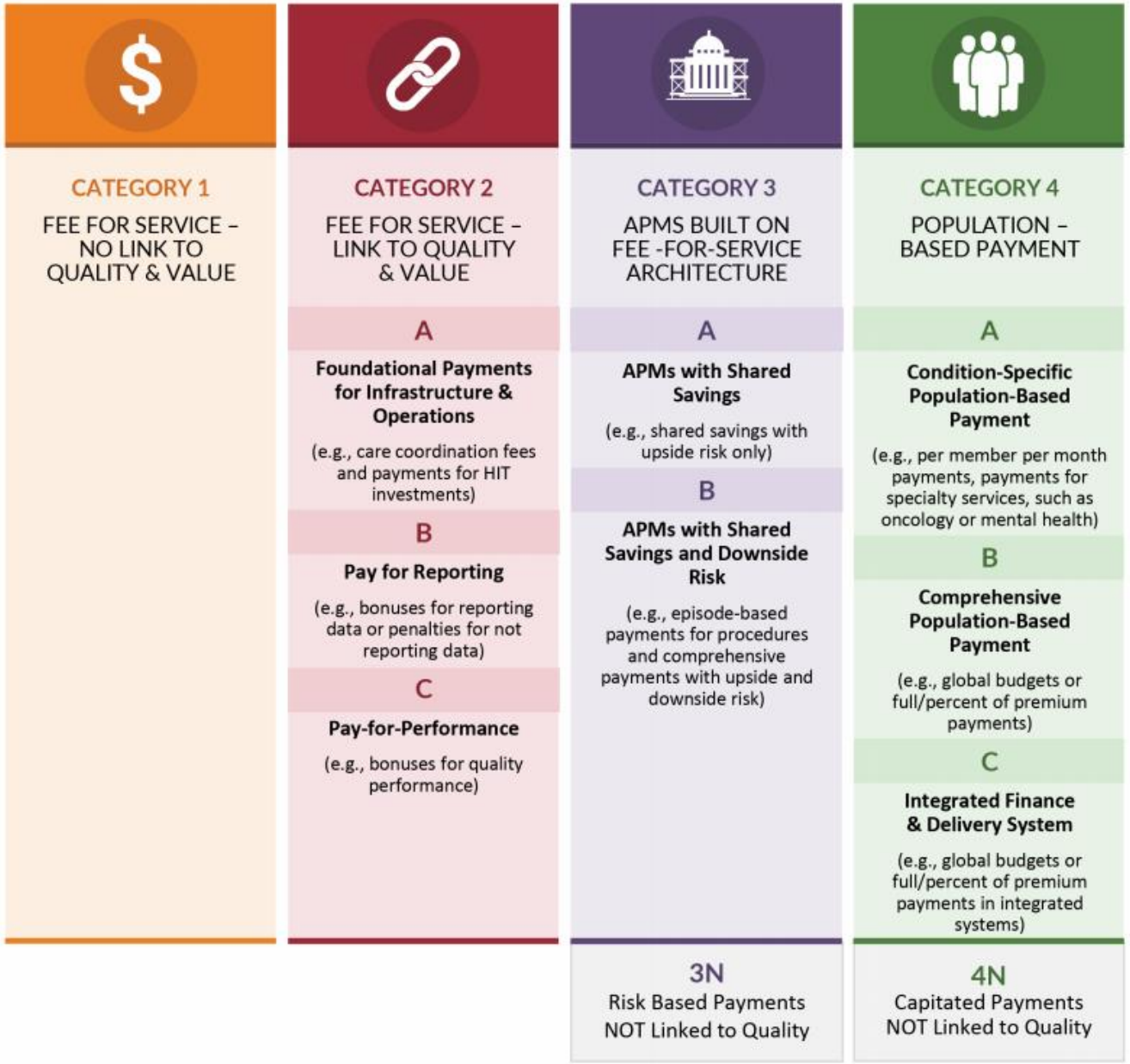
Overview

- Four categories and eight subcategories



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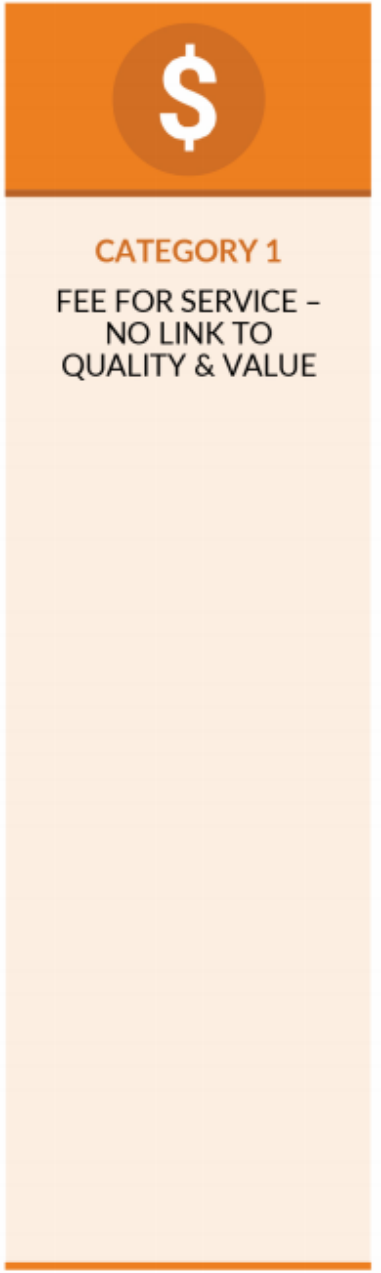
Category 1

Fee for service (FFS) with no link to quality and value

- Traditional FFS payments
- Includes diagnosis related groups (DRGs) not linked to quality and value



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Category 2

Fee for service (FFS) linked to quality and value

- Utilizes traditional FFS payments but adjusted based on investments in infrastructure to improve clinical services or care

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Category 2A

- Includes payments meant to improve infrastructure
  - Payment rates not adjusted to account for performance on quality measures

- Examples include payment for care coordination or electronic health record (EHR) upgrades

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Category 2B

- Payments that incentivize reporting of quality data to the health plan and ideally, the public

- Not linked to quality performance

B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)

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Category 2C

C

Pay-for-Performance

(e.g., bonuses for quality performance)

- Payments linked to performance (both positive and poor)
- Requires a set of quality measures to be included in payment model

Note: Categories 2A and 2B are meant to be foundational on the way to category 2C and beyond.

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Category 2 Payment Model Example:
Anthem– Quality Cancer Care

Overview	APM Framework category	Approaches to cost assessment	Approaches to quality assessment	Method and magnitude of payment adjustment	Additional infrastructure and operational investments
Includes "cancer care pathways" based on medical evidence and guidelines. Providers receive treatment planning fees for choosing pathways.	**2(C) Pay for performance**	N/A	Pay for performance with quality gates	One time $350 fee at the onset of treatment, then a $350 PMPM when patient receives treatment on the pathway	N/A

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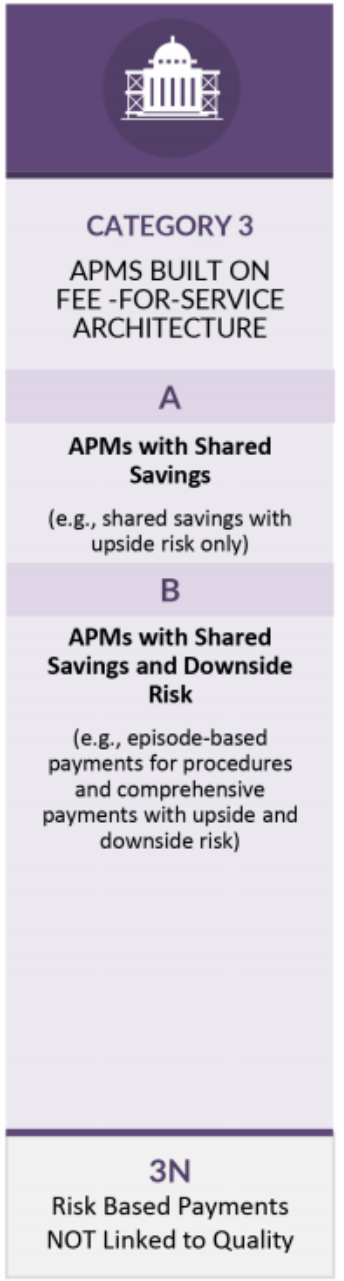
Category 3

Alternative payment models (APMs) built on FFS architecture

- Based on cost (and sometimes utilization) performance relative to a benchmark
- Includes episodes of care or other types of bundled payments
- Requires providers be held accountable for performance on measures of appropriate care (*Choosing Wisely*, for example)



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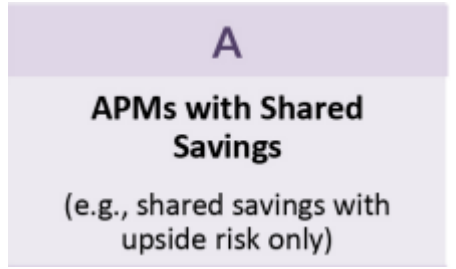
Category 3A

- Payment models in this category include shared savings to providers who generate cost savings against a target, if quality performance requirements are met

- Includes “incentive-at-risk” programs, like CPC+ Track 1



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Category 3B

- In addition to shared savings, payments in category 3B include downside risk. Providers are responsible for a portion of losses if cost and/or utilization and quality targets are not met in the performance period.

B
APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

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Category 3 Payment Model Example:
Federally Qualified Health Center Urban Healthcare Network (FUHN) – Safety Net Medicaid ACO

Overview	APM Framework category	Approaches to cost assessment	Approaches to quality assessment	Method and magnitude of payment adjustment	Additional infrastructure and operational investments
Medicaid "virtual" ACO of FQHCs in Minnesota	**3(A)– APM build on FFS architecture**	A cost "benchmark" is set each year based on the attributed Medicaid population. FUHN is then accountable for the total cost of care for defined set of services.	Organizations must demonstrate relative improvement in specific measure set. Relative only to other organizations within FUHN due to unique patient population characteristics.	"Achieved total cost of care (TCOC) savings are shared equally (50/50) between FUHN and DHS only when a threshold of 2% of savings is achieved." No downside risk	N/A

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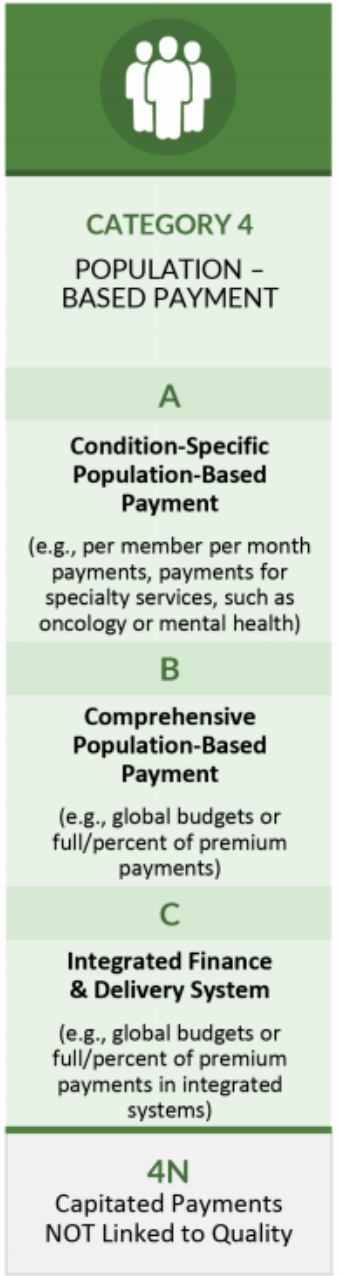
Category 4

Population-based payment

- Prospective, population-based payments
- Include same accountabilities for appropriate care measures as category 3

Note: Category 4 payment models may be challenging to implement for provider organizations outside of integrated delivery and finance systems.



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Category 4A

- Bundled payments for the comprehensive treatment of specific conditions

A
Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

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Category 4B

B
Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)

- Payments to cover all a patient's health care needs
- In this category, providers and payers are organizationally separate

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Category 4C

- Represent payment models that are part of integrated financing and delivery systems

- Require appropriate incentives

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Category 4 Payment Model Example:
Tufts Health Plan

Overview	APM Framework category	Approaches to cost assessment	Approaches to quality assessment	Method and magnitude of payment adjustment	Additional infrastructure and operational investments
FFS payment reconciled with an annual global budget. Commercial HMO population attributed to primary care providers participating in 100% risk above and below negotiated PMPM.	**4(B) – Comprehensive population-based payment**	Annual budget set on prior claims. Unit cost, utilization rates and case mix all examined.	Includes: total medical expenses, quality measures, practice and referral patterns, cost and utilization	Upside and downside risk. Delivery systems decide how to allocate risk amongst itself, alongside guidance from Tufts Health Plan	Investments in technical assistance and quality improvement

The APM Framework and Comprehensive Primary Care Plus (CPC+)

- CMS' CPC+ Track 1 payment model is considered a category 3A model because of its shared savings and use of utilization metrics

- Oregon CPC+ Payer Group example and use of the framework

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Resources

- Health Care Payment Learning & Action Network (HCP LAN) APM Framework: https://hcp-lan.org/apm-refresh-white-paper/

- HCP LAN Primary Care Payer Resource Bank: https://hcp-lan.org/pac-portal/

- Addendum to APM Framework White Paper, with example payment models: http://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf

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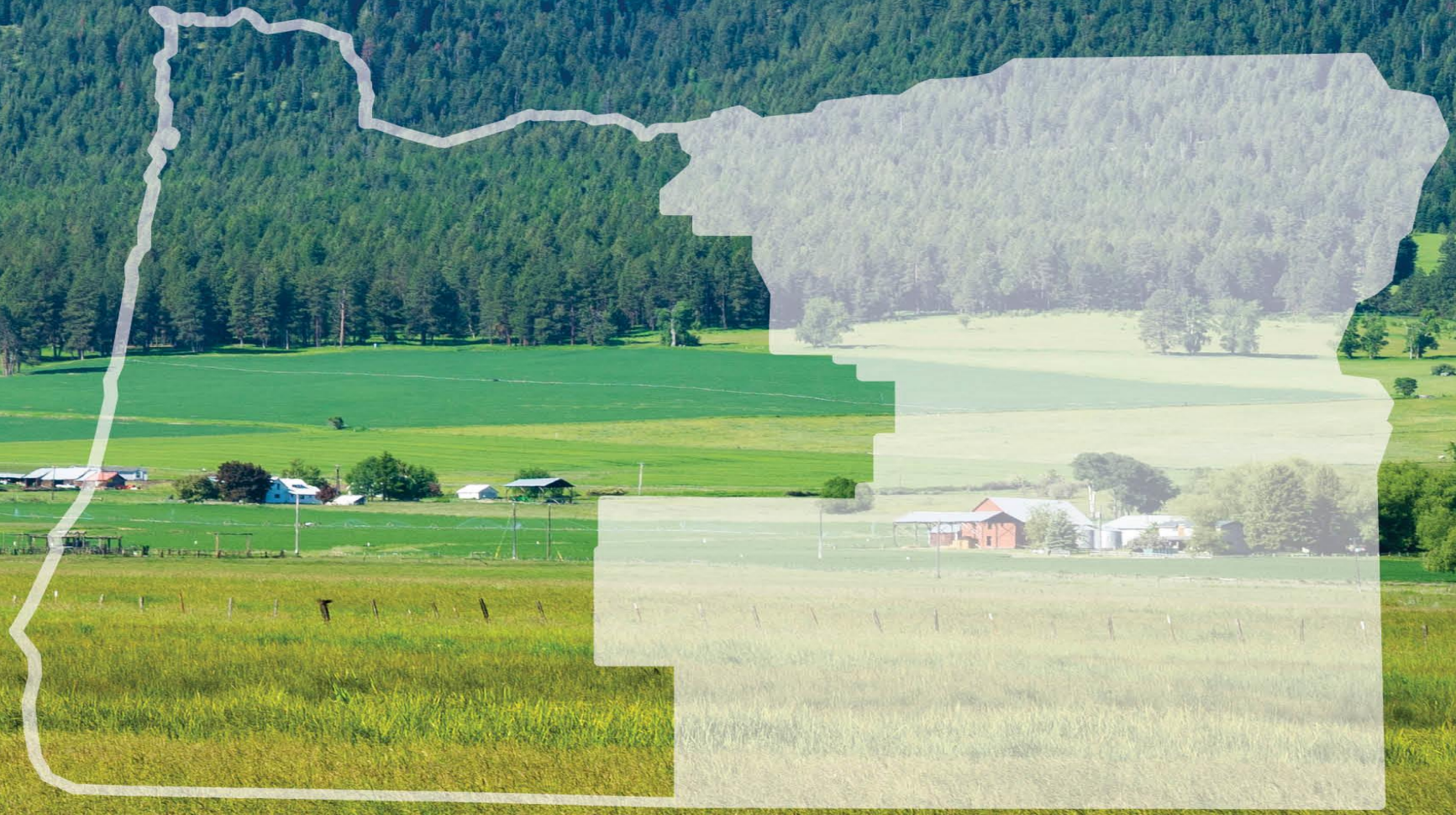
EOCCO PAYMENT METHODOLOGIES
and
THE LAN FRAMEWORK

LESSONS LEARNED IN RURAL OREGON

Healthcare Transformation Council of Idaho
Payer Provider Workgroup
2/24/2020
Chuck Hofmann, MD, MACP
Clinical Consultant, Eastern Oregon CCO

EOCCO



50,000 square miles (OR: 98,500 square miles)
195,000 residents (OR: 4,150,000 residents)
50,000 enrollees

EOCCO Delivery System*

- 10 Area Hospitals
  - 7 of 10 are Critical Access and OregonType A (<50 beds, >30 mi) & Hospitals
  - 5 of 10 belong to health districts
  - None are tertiary hospitals

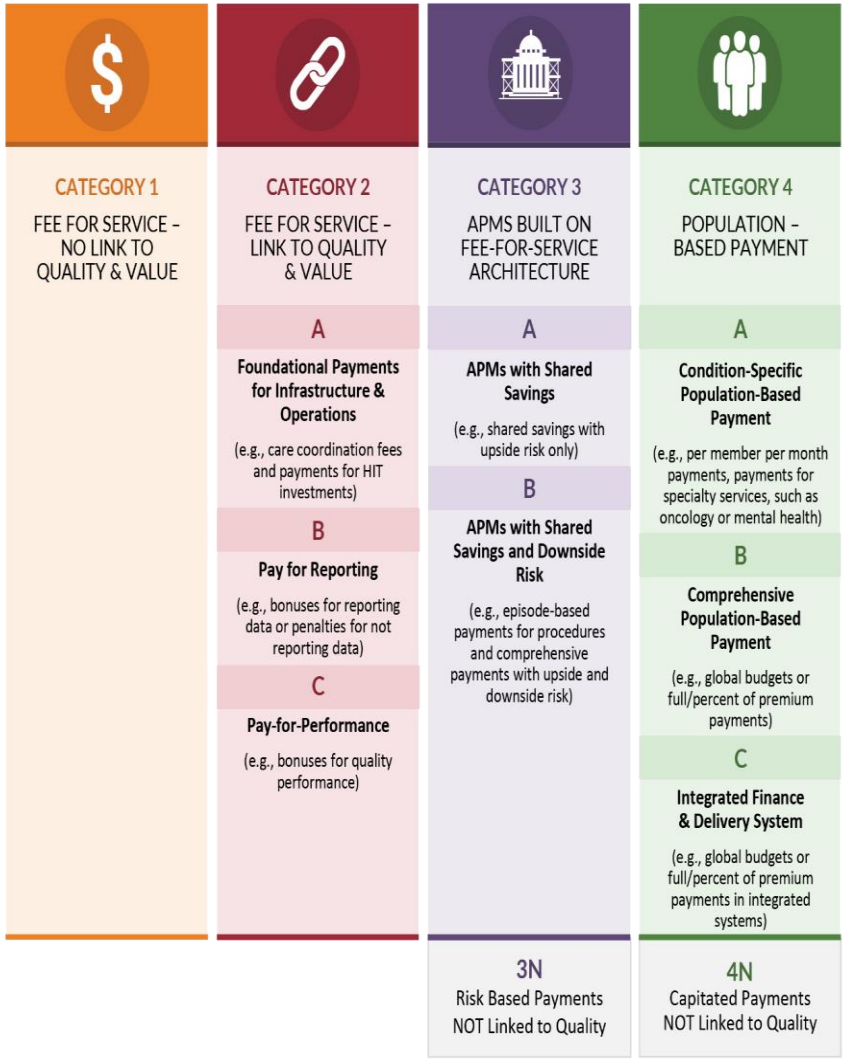
- Primary Care Providers
  - ~ 60 widely dispersed clinics, many sole provider entities
  - 24 are Rural Health Clinics (RHCs)
  - 7 are Federally Qualified Health Centers (FQHCs)
  - Over 90% of members are served by state-certified medical homes

- Additional Providers
  - Specialty Medical Care
  - Behavioral Health
  - Dental Health
  - Non-emergent Medical Transportation

**Includes Oregon, Idaho & Washington providers*

LAN APM Framework

- First published in 2016 and then refreshed in 2017, the APM Framework established a common vocabulary and pathway for measuring and sharing successful payment models
- 4 Categories & 8 Subcategories
- Has become the foundation for implementing APMs



Oregon Health Authority Payments to EOCCO

- Global actuarially-based premium with rates for each class (non-ACA adults, ACA adults, children, ABAD/OAA with/without Medicare)

- Risk-adjusted

EOCCO Care Management Program

- Recognizes that costs of a highly-functioning Primary Care Medical Home exceeds FFS reimbursement.
- Begun in 2013
- PMPM payments currently range between $18 and $23
- 2013 – 2019: Payments tier-based
- 2019 – on: Payments partially tier-based, partially risk-based, and partially performance-based
- LAN Category 2A – Foundational Payments for Infrastructure and Operations

EOCCO Quality Bonus Program

- Based on state-mandated quality measures
- Begun in 2013
- Size of total distribution adjusted by Board annually depending on system quality measure performance
- Distribution formula adjusted annually by Clinical Advisory Panel
- Distributions based on a clinic's overall performance on meeting quality measure targets
- LAN Category 2C – Pay for Performance

EOCCO Shared Savings Program

- Begun in 2014
- Surpluses annually
- Formula adjusted annually
- Currently 3 Funds (primary care fund removed)
- LAN Category 3N – APM with Shared Savings not linked to quality

OHA CCO 2.0 Care Delivery Area Priorities

- Children's Care
- Maternity Care
- Hospital Care
- Behavioral Care
- Oral Care

- All areas must be implemented by 2025

OHA CCO 2.0 LAN Framework Requirements

- 2023: 50% of payments ≥ Category 2C
  20% of payments ≥ Category 3B

- 2024: 60% of payments ≥ Category 2C
  25% of payments ≥ Category 3B

- Current: 45$ of payments ≥ Category 2C
  27% of payments ≥ Category 3B
  Also: 5 contracts = Category 4B
  1 pilot = Category 4C

EOCCO CCO 2.0 APM Implementation Strategies

- Continue to refine Care Management, Quality Bonus, and Shared Savings programs
- Implement Children's and Maternity CDA APMs in 2020
- Implement Hospital and Behavioral CDA APMs in 2021
- Implement Oral CDA APM in 2023

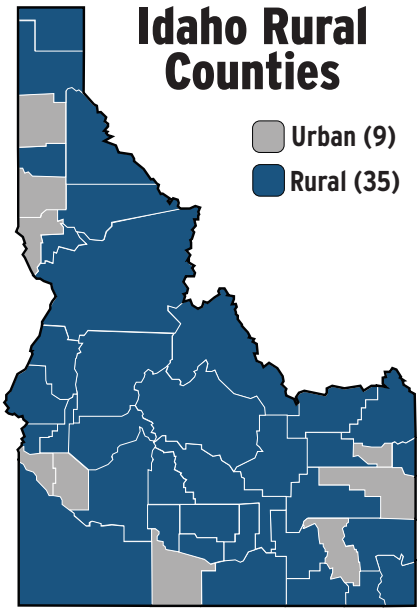
QUESTIONS?

Idaho Division of Public Health

Value-Based Healthcare & the Healthcare Transformation Council of Idaho

Background

Value-based healthcare is a delivery model whereby providers, including hospitals, clinics and physicians, receive payments based on patient health outcomes and cost of care. Value-based payment agreements reward providers for helping patients to receive appropriate health screenings, benefits from preventive healthcare, improved health, reduced effects and incidences of chronic diseases, and live, overall, healthier lives. Patients receive cost-effective care that is designed to avoid unnecessary services, duplicative testing, or more expensive care than is necessary to achieve the desired outcome.



The Difference Between Value-Based Care and Fee-for-Service Care

In the fee-for-service model of care, providers receive payments based on the amount of healthcare services they deliver, regardless of whether the service was necessary, harmed the patient, or if a less expensive option would have produced the same or better outcome. The reimbursements do not reward quality, which creates adverse incentives that drive up costs. Fee-for-service payments also promote fragmentation, because providers receive payments for each service delivered, as opposed to value-based payments that, in the most advanced models, are fixed payments for all care or an episode of care that helps integrate and coordinate care.

Healthcare in Idaho

Idaho lags behind the nation in adopting value-based payment models. For rural and frontier providers, hospitals and clinics, implementing value-based payment models remains particularly difficult, as they often have limited financial resources to invest; lack interoperable data systems; face challenges with managing population health over large, sparsely populated geographical areas; and experience burdens of satisfying performance measurement and reporting requirements.

59% **National rate for value-based payments**

29% **Idaho rate for value-based payments**

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IDAHO DEPARTMENT OF HEALTH & WELFARE
January 2020

Benefits of Value-Based Care

Transitioning to a value-based healthcare delivery model provides many benefits to the state, including:

- Developing programs to align with public expectations of the healthcare delivery system while focusing efforts on containing state healthcare costs.
- Providing incentives for healthcare providers to deliver the best care at the lowest cost and help individuals achieve their best possible health.
- Advancing healthcare quality, improving population health and containing or reducing healthcare costs.

The Healthcare Transformation Council of Idaho (HTCI)

In February 2019, the state established the HTCI to continue Idaho's transformation efforts and movement towards value-based payment models. HTCI receives support from the Office of Healthcare Policy Initiatives (OHPI) in the Bureau of Rural Health and Primary Care, Division of Public Health.

HTCI and OHPI's Goal: By 2023 advance Value-Based Payments in Idaho from 29% to 50%

Statewide Coordination, Collaboration and Support

HTCI provides leadership, coordination and communication to advance value-based healthcare in Idaho, in addition to leveraging resources strategically to overcome fragmented systems of care.

OHPI supports HTCI by implementing strategies and tactics that encourage the adoption of value-based models, so that Idaho can achieve a more efficient healthcare system with improved outcomes. OHPI also convenes workgroups, under the direction of HTCI, to move ideas into action. Current initiatives include advancing telehealth, identifying cost drivers to contain healthcare costs and developing an innovative value-based model for rural and frontier areas.

Although the four-year Statewide Healthcare Innovation Plan (SHIP) successfully initiated the shift from volume to value, additional time and collaboration remains critical to advancing healthcare reform in the state. Achieving value-based healthcare outcomes is a long-term, time-consuming and labor-intensive endeavor for healthcare providers and organizations. No state has already solved this problem that would allow Idaho to simply implement a solution. Many providers are already engaged in transformation efforts and are increasingly working toward value-based payment arrangements; however, challenges and barriers persist.

What Will Help the State Transition Successfully?

- Sustained funding for HTCI and OHPI to continue developing, implementing and leading statewide value-based efforts.
- Providers are investing significantly in the infrastructure necessary to be successful under value-based arrangements and incurring financial losses in the transition, which often takes years. Providers participate because it's the right thing to do, however, it is contrary to their best interest in the fee-for-service environment. Continuing to engage them in this is critical to success.
- Providers, clinics, hospitals and health system leaders must improve clinical quality, reduce inefficiencies and manage costs to thrive in a value-based setting.
- Resources, education and technical assistance will help support healthcare transformation to value-based models, especially in rural and frontier areas.

Idaho Division of Public Health

Examples of How Patients Benefit from Value-Based Healthcare

Care coordination contributes to value-based healthcare and improved health.

Scenario: Mr. Jones is a 54-year-old man with asthma

Fee-for-service model:

Mr. Jones makes repeated trips by ambulance to the hospital emergency department for shortness of breath. Each time, the emergency room physician and staff provide the necessary medications and treatments to alleviate his shortness of breath and discharge him home. Mr. Jones' shortness of breath continues to worsen, and he is transported to the emergency room nearly every three to four weeks. He receives multiple bills every time he is transported and treated, and he can no longer afford to pay the amount due.

Value-based healthcare model:

Mr. Jones made a trip by ambulance to the hospital emergency department for shortness of breath. The emergency room physician and staff provided the necessary medications and treatments to alleviate his shortness of breath and, before discharging him home, he and his family met with the nurse case manager. The case manager learned that Mr. Jones has a primary care provider that prescribed appropriate asthma medications, and that his clinic recently hired a nurse care coordinator. The care coordinator visited Mr. Jones at home and learned about issues impacting his health that were not apparent to his provider: his adult daughter recently moved home and smokes in the house; and Mr. Jones cannot afford his prescription medications but was embarrassed to tell his provider. The care coordinator spoke with Mr. Jones and his daughter to develop a plan to maintain a healthier home environment and spoke to his provider and pharmacy to find a more affordable medication. Mr. Jones had no trips to the emergency department in the following months.

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IDAHO DEPARTMENT OF HEALTH & WELFARE
January 2020

Appropriate screening contributes to value-based healthcare through early detection.

Scenario: A primary care clinic has a very low rate of colon cancer screenings for their patients.

Fee-for-service model:

Clinic staff understand that age-appropriate disease screening is essential to prevention, early detection, and management; however, patients just do not seem to schedule their colonoscopy when it is recommended and, under fee-for-service, there is no incentive for the clinic to spend the additional resources needed to reach out to patients and make the case for why they should proceed with the screening.

Value-based healthcare model:

The primary care clinic recently joined a value-based care network of providers. They were unhappy to learn their colon cancer screening rates were below every other clinic in the network. The clinic generated a list of eligible patients that had not received their colon cancer screening and contacted each patient. They learned the screenings did not occur for a variety of reasons and staff worked with every patient to resolve the issues. They referred patients for testing and followed up with them to assure the screening was completed. Months later, the clinic is the top performer in the network. Additionally, six patients were found to have cancerous lesions and had interventions while the cancer was early, more manageable, and far less costly to treat.

Advanced care planning contributes to value-based healthcare while aligning with a patient's end-of-life wishes.

Scenario: Mrs. Smith is an 89-year-old woman with diabetes and heart failure.

Fee-for-service model:

Mrs. Smith recently moved to Idaho to live with her son and daughter-in-law. Before moving to Idaho, she was hospitalized four times in the past nine months, was prescribed 11 different medications, and used oxygen to walk more than 20 feet. Her doctor also told her that her kidneys were failing, and she would need to start dialysis. Her care providers assumed she would opt for all possible treatments, but no one took time to sit down with her and her family to discuss her wishes.

Value-based healthcare model:

Mrs. Smith sees a new provider after moving to Idaho. In preparing for the appointment, her new provider reviewed her medical records and scheduled a longer visit to discuss her end-of-life wishes. Mrs. Smith's son accompanied her to the appointment and said he had never broached the subject with her. The provider discussed her current health status, including the need for dialysis, and asked Mrs. Smith about her personal preferences. She told her doctor that if her condition worsens, she wanted to remain comfortable and stay at home. The provider connected Mrs. Smith and her family to hospice and palliative care for the support and care she had requested. The patient remained at home and kept comfortable; had meaningful interactions with her family and friends up until the end; and significant hospital, intensive care, and physician costs were averted.

Telehealth is a strategy providers may use to support value-based healthcare by providing readily accessible care instead of higher cost alternatives.

Scenario: Cody, an active 10-year-old, wakes up early in the morning to get ready for school. He is complaining about red and itchy eyes.

Fee-for-service model:

Cody's mom is getting ready for work and is not sure whether it is safe to send Cody to school. She decides to take him to an urgent care clinic for a diagnosis and get to work as quickly as possible. Unfortunately, there is a long wait. While Cody's mom is finally glad to hear he has severe allergy symptoms and not an infection, she has missed more time off work than anticipated.

Value-based healthcare model:

When Cody wakes up with red, itchy eyes, his mom connects to their primary care provider's practice through a secure audio and video connection. The provider reviews Cody's health history, asks his mom some questions, and examines his eyes via webcam. They determine Cody can be safely treated with over-the-counter antihistamines and understand they would be referred for an in-person visit, depending on how he responds. Cody's primary care provider group is part of a value-based healthcare network. Providers are incentivized to deliver the most efficient and effective care at the lowest cost. Cody goes to school and his mom does not miss much work as a result of the appointment.

Hospitals and health systems positively impact the social determinants of health by reinvesting shared savings from value-based healthcare models.

Scenario: A local hospital serves an area of the state with high poverty and low per capita income. Food insecurity is often an issue for their patients and newly diagnosed diabetics cannot access the type of food needed to achieve better health.

Fee-for-service model:

The hospital advises patients about a small, local foodbank; however, the foodbank does not have the resources to keep up with demand or the fresh produce needed for the hospital's diabetic patients. While the hospital supports the food bank through local fundraising by volunteers, their patients cannot achieve their best possible health without proper nutrition.

Value-based healthcare model:

The hospital participates in a value-based shared savings model with public and commercial payers. At the end of the year, the hospital receives a portion of the money saved and reinvests the savings in the community. This reinvestment will improve the health of the community and continue to drive down healthcare costs, which will result in even more savings. This year, the hospital establishes a collaborative partnership with other health and social service agencies in the community. The partnership is focused on increasing access to healthy food and education for diabetic patients. They also create a program for newly diagnosed diabetics and provider education, two months of appropriate food, and a weekly visit from a community health worker — all at no charge to the patient. As a result, the hospital is reducing unnecessary hospital admissions and emergency department visits, while the clinic is seeing an overall improvement in outcomes for diabetic patients.